MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DIVISION OF WORKERS' COMPENSATION

VERIFICATION OF REHABILITATION TREATMENT

Injury Number: Date of Injury: SSN:

Employee: **Rehabilitation Facility:**

Phone Number: _____
Contact Person: _____

OUTPATIENT TREATMENT

Type of rehabilitation received *(be specific)*: _____

_____

_____

Date rehabilitation began: _____ # of days per week therapy ordered: _____

List all dates client has attended therapy:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

List all dates client cancelled or did not attend scheduled therapy:

_____ _____ _____ _____

_____ _____ _____ _____

Please list date employee returned to work: _____

INPATIENT TREATMENT

Type of rehabilitation received *(be specific)*: _____

_____

_____

Admission Date: _____ # of days per week therapy ordered: _____

Is therapy continuing at present? ☐ Yes ☐ No If "No," list discharge date: _____

List all dates client received therapy:

_____ _____ _____ _____

_____ _____ _____ _____

List all dates client did not receive scheduled therapy:

_____ _____ _____ _____

_____ _____ _____ _____

Please return form to:

Fax: 573-522-1623

Phone: 573-526-3876

Mail: Attn: Physical Rehabilitation
Missouri Division of Workers' Compensation
P. O. Box 58
Jefferson City, Missouri 65102-0058